

Anatomic Resection of Left Liver Segments

I read with interest the article on the anatomical resection of the left liver segments by Machado et al¹ that appeared in the December issue of ARCHIVES.

Machado et al² first published a paper about right portal pedicle isolation for right segmental liver resections and then this one about the same problem on the left liver. Like the authors, I too am interested in the extraglissonian approach to the liver portal pedicles and consider it very important and useful during right liver segmental resections (technique reported elsewhere).³ After this report, each time I have had to remove a tumor in the left liver, I have tried to isolate and clamp the segmental glissonian pedicle exactly in the same way as described by Machado et al. Unfortunately, the results have not been so enthusiastic. I realize that, except for the total control of the entire left portal pedicle, which is complete and reliable, the isolation of the segmental branches for segment II, III, and IV are not, resulting often incomplete. This is because of the fact that the segmental glissonian sheaths arising from the left pedicle and umbilical fissure are multiple and variable for each of these left segments. Frequently, some pedicles arise from the cranial part of these structures, deep in the left liver parenchyma,⁴ that can be reached and properly exposed at the end of liver transection. Machado et al did a good job of describing the pedicles that are located superficially to the inferior face of the left liver, which are important and probably the main ones, but they are sometimes not the unique pedicle for that segment.

For these reasons, I feel that it is necessary to warn the readers, based on reported anatomic studies and personal experience, about the possible presence of these other pedicles that may be responsible for incomplete resection (if one resects on an ischemic demarcation basis) and/or notices an increase in blood loss during liver resection.

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2. Machado MA, Herman P, Machado MC. A standardized technique for right segmental liver resections. *Arch Surg*. 2003;138:918-920.
3. Batignani G. Hilar plate detachment and extraglissonian extrahepatic anterior approach to the right portal pedicle for right liver resections. *J Am Coll Surg*. 2000;190:631-634.
4. Couinaud C. Le sectoriectomies portales. In: *Le Foie: Etudes Anatomiques et Chirurgicales*. Paris, France: Masson & Cie Editeurs; 1957:348-399.

In reply

We want to thank Prof Batignani for his letter describing his personal experience with the left glissonian pedicles approach. As stressed by his letter, our technique for isolation of the left hepatic pedicle is always reliable and complete. We agree that sometimes the pedicles for each left liver segment may be located deep in the hepatic parenchyma. If one tries to dissect too far from the emergence of these pedicles, they may be faced with secondary branches resulting in incomplete ischemia of the corresponding left liver segment. This information is very important for readers. However, when faced with this problem, we encircled the main left portal pedicle and pulled it downward. This simple maneuver enhances the identification and further clamping of all left liver segmental glissonian sheaths, even the deepest ones.

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Randomized Trial of Fixation vs Nonfixation of Mesh in Total Extraperitoneal Inguinal Hernioplasty

What is a clinically relevant difference in recurrence rate in groin hernia repair when performed by experts? A 0% recurrence rate is no doubt an excellent result. But how about 3%? It is good, but is it excellent? Is the difference clinically relevant?

I congratulate the authors of the article on fixation vs nonfixation of mesh in laparoscopic total extraperitoneal inguinal hernioplasty, published in the December issue.¹ It is the first published randomized trial on an important and controversial technical detail in this operation. Adding to the ongoing global discussion on whether to fixate the mesh, the study contains clinically relevant outcome variables such as recurrence rate and chronic pain and costs associated with staples.

The authors claimed that mesh nonfixation yields an unaltered recurrence rate and costs €400 (\$500) less, ie, the null hypothesis was confirmed. They also suggested that mesh fixation only has an advantage in direct bilateral hernias. It may be true, but I question that these 3 conclusions are unequivocally supported by their published data.

Absence of statistical evidence is not evidence of absence of true difference.² The most important issue is